FORM SI-02 **OFFICE OF WORKERS' CLAIMS**
REV. 01/04 **FRANKFORT, KENTUCKY 40601**

EMPLOYERS APPLICATION FOR PERMISSION TO CARRY HIS OWN RISK WITHOUT INSURANCE

TO THE OFFICE OF WORKERS' CLAIMS OF KENTUCKY: _____ , 20____.

The undersigned, an employer subject to the provisions of The Kentucky Workers' Compensation Act, hereby applies for a certificate of his-its financial ability to pay compensation directly, without insurance to injured employees, and determine whether he-it possesses sufficient financial ability to render certain the payment of such compensation, said applicant under oath hereby states the following facts: (Where space is insufficient to answer any question, extend answer on attached page or pages.)

1. Name of applicant: _____

2. Address: _____
(Number) (Street) (City or Town)

_____
(County) (State)

3. The applicant is _____(State whether individual, co-partnership, corporation, receiver or trustee.)

3.a If consolidated balance sheet give list of subsidiary companies included: _____
_____
_____

4. Describe briefly the general character of the operations performed and the articles manufactured or compounded at or away from the plant or the premises of the applicant.
_____

5. Description of Employment: _____
_____

Location of Plant Or Plants	**Kind of Employment**	**Average # of Employees at all points**	**Average # of Employees in Kentucky**	**Actual Payroll For all employees In Kentucky**
TOTALS:				

6. If a corporation, partnership, or Limited Partnership, list below names of officers, directors, and residence of each.
_____

7. Safety, sanitation and welfare conditions:
Is your plant inspected otherwise than by State authority? _____
If so, by whom? _____
Have you fulfilled all safety requirements of the Labor or Mines and Mineral Departments?
_____

Have you a committee of safety whose duty is to recommend safety devices and to secure compliance with statutes or general orders of the above-mentioned agencies as to safety and sanitation? _____

Do you maintain a hospital in connection with your establishment? _____
If so, state description of its equipment and service: _____

8. Federal Employer I.D. # _____ State Employer I.D. # _____
Federal and State I.D. #'s are needed for each subsidiary, if any are to be included.

9. In consideration of the approval of this application the applicant hereby expressly agrees as follows:

a. That this privilege may be revoked at any time in the discretion of The Office of Workers' Claims.

b. That the applicant will fully discharge by cash payment all installments of compensation for partial disability, promptly, when due, and liability for physician fees, hospital service, hospital supplies within 30 days after such liability shall be determined either by an agreement or an award.

c. If The Office of Workers' Claims so requires, the applicant, within thirty days after his-its continuing liability to pay compensation to an injured employee for a definite period for a permanent injury or to the dependents of a deceased employee, for his death, has been determined either by an agreement or an award, will make a special deposit, with some bank or trust company within the Commonwealth of Kentucky to be approved by the Office of Workers' Claims of the full amount of such terms that it can be withdrawn only on the checks of the applicant, payable to the person or persons entitled thereto, and having attached thereto a voucher for the amount thereof, executed by the person or persons to whom such check is payable.

d. The applicant agrees to file with the Office of Workers' Claims for its approval before the granting of this application, an acceptable security, indemnity of bond, to secure to such an extent as the Office of Workers' Claims may direct the payment of compensation liabilities as they are incurred.

10. Requested effective date to become self-insured: _____

_____
If Corporation

By _____
President and Managing Officer

COMMONWEALTH OF KENTUCKY
COUNTY OF _____

_____ , being first duly sworn, upon oath, says that the facts set forth in the foregoing application are true.

_____

Subscribed and sworn to before me, this _____ day of _____, 20____.

_____
Notary Public

My commission expires on the _____ day of _____, 20____.